Family Care Encounter Reporting 2.5 --- Data Dictionary View (HEADER)

This document describes the various data elements contained in the encounter record you will extract and send to the State. The description includes things like data element name, length and data type. In addition, there is a brief definition of the data element as well as some of the validation rules Encounter Reporting will use to verify the data you send us. It's primarily intended as a technical document to assist the MCO IT personnel in creating an extract from your claims history data

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot) / Format	Is data required?	Default Value	ID#	Error cat
CMO MA ID	8 Fixed	**N** (00000000)	Y	None	H1	H
Data Element Description:	Eight digit certified Medicaid provider number assigned to the CMO. Currently FDL = 69005500, LAX = 69005600, PRTG = 69005700, RICH = 69005900, MCDA = (keylink=69005800, MCDA=69005810, WPS=69005820.)					
Validation Rules:	Must exist in the Master Lookup table.					
Submission Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H2	H
Data Element Description:	The date the submission was generated at the MCO.					
Validation Rules:						
Begin Posting Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H3	H
Data Element Description:	The beginning process date used to extract encounter records for the submission.					
Validation Rules:						

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot) / Format	Is data required?	Default Value	ID#	Error cat
End Posting Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H4	H
Data Element Description:	The ending process date used to extract encounter records for the submission.					
Validation Rules:						
Number of Records Transmitted	8 Max	N	Y	None	H5	H
Data Element Description:	The number of detail records that are contained within the submission.					
Validation Rules:	Number of Records Transmitted must be equal to the number of detail records in a submission.					
CMO:Submission_type	10 Max	A	Y	TEST	H6	H
Data Element Description:	The submission type must be Production					
Validation Rules:	Must be 'Production'. This value is not case sensitive					

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Service Delivery Type	2 Fixed	A (00)	Y	None	NA	D76	R
Data Element Description:	The service delivery mechanism. Examples are PC = Program Contract providers, NC = non-program Contract providers, IS = Informal Supports, PH = Public Health, etc.						
Validation Rules:	Must exist in the Master Lookup table.						
CMO MA ID	8 Fixed	**N** (00000000)	Y	None	NA	D02	R
Data Element Description:	Eight digit certified Medicaid provider number assigned to the MCO. Currently FDL = 69005500, LAX = 69005600, PRTG = 69005700, RICH = 69005900, MCDA = (keylink=69005800, MCDA=69005810, WPS=69005820.)						
Validation Rules:	Must exist in the Master Lookup table.						
Data Source	2 Fixed	AN (00)	Y	01	NA	D03	R
Data Element Description:	Identifies the source of data. 01 = "Claim System", 02 = "ISP", 03 = "Accounts Receivable", 04 = Predictive Model, and 05 = Accounts Payable. Other sources might include A/P or Timekeeping module/Payroll.						
Validation Rules:	Must exist in the Master Lookup table and valid for this organization.						
Record ID	80 Max	ANPlus	Y	None	NA	D04	R
Data Element Description:	Unique ID assigned by the MCO to uniquely identify the record (claim detail line). This ID is unique to every transaction submitted.						
Validation Rules:							

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Parent Record ID	80 Max	ANPlus	S	None	NA	D05	A
Data Element Description:	The unique ID assigned by the MCO to identify the record (claim detail line) that is being adjusted. This field is used only when adjusting an existing encounter record. In a credit/debit adjustment both the credit and debit transactions will reference the same transaction being adjusted.						
Validation Rules:	Used only when the record being submitted is an adjustment. Must match the Record_ID of the record being adjusted. Required if record being submitted is an adjustment.						
Original ID	80 Max	ANPlus	S	None	NA	D06	A
Data Element Description:	The unique ID assigned by the MCO to reference the first encounter that this and/or all subsequent adjustments were made from. This ID will always reference a Record_ID.						
Validation Rules:	Must exist on an Original record for that organization. Must exist on an adjustment record						
Claim Status	1 Fixed	A (0)	Y	None	NA	D07	R
Data Element Description:	The current status of the encounter (claim detail line). (P = Paid; D = Denied)						
Validation Rules:	Must be either P or D.						
Record Type	1 Fixed	A (0)	Y	None	NA	D08	R
Data Element Description:	The type of encounter transaction. O = An unadjusted transaction. C = Adjusting entries that usually come in pairs. The Credit is to reverse the actual transaction being adjusted and the Debit is to "replace" the transaction being adjusted.						
Validation Rules:	Must be O or C.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Adjustment Type	1 Fixed	A (0)	S	None	NA	D09	A
Data Element Description:	The type of adjustment. Only applicable for transactions that are "adjusting" a former encounter transaction. These may be assigned by the MCO for credit/debit encounter transactions. R = A transaction that is the credit to reverse the adjusted transaction. N = A transaction that is the debit to replace the adjusted transaction.						
Validation Rules:	Required if Record Type is "C".						
Adjustment Type Detail	2 Fixed	A (00)	N	None	NA	D10	A
Data Element Description:	Specifies the type of adjustment. FC = An adjustment that fully reverses the adjusted transaction resulting in funds being paid back to the MCO from the provider. PC = An adjustment that partially reverses the adjusted transaction resulting in some funds being paid back to the MCO from the provider. NC = An adjustment that has no financial affect but changes demographic or other statistical data.						
Validation Rules:	Must be "FC", "NC" or "PC"						
Primary ANSI Reason Code	3 Max	AN	S	None	NA	D11	S
Data Element Description:	Primary standard ANSI reason code **(Claim Adjustment Reason Codes).**						
Validation Rules:	Must exist in the Master Lookup table. If the Claim Status field = "D" or if the amount paid differs from the amount charged a reason code must be provided in the Primary ANSI Reason Code field.						
Second ANSI Reason Code	3 Max	AN	N	None	NA	D12	S
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**						
Validation Rules:	Must exist in the Master Lookup table.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Third ANSI Reason Code	3 Max	AN	N	None	NA	D13	S
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**						
Validation Rules:	Must exist in the Master Lookup table.						
Fourth ANSI Reason Code	3 Max	AN	N	None	NA	D14	S
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**						
Validation Rules:	Must exist in the Master Lookup table.						
Fifth ANSI Reason Code	3 Max	AN	N	None	NA	D15	S
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).** .						
Validation Rules:	Must exist in the Master Lookup table.						
Sixth ANSI Reason Code	3 Max	AN	N	None	NA	D16	S
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**						
Validation Rules:	Must exist in the Master Lookup table.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
CMO Reason Code	6 Max	ANPlus	N	None	NA	D17	S
Data Element Description:	County specific reason code. This is a reason code created and maintained by the county.						
Validation Rules:							
MA Billing Provider ID	8 Fixed	**N** (00000000)	S	None	NA	D18	P
Data Element Description:	Medicaid Billing Provider ID						
Validation Rules:	Required when **Billing Provider ID** field is not used otherwise it is optional. Must exist in the Master Lookup table.						
Billing Provider ID-Qualifier	2 Max	AN	S	None	ID Code Qualifier (AN, L=2)	D19	P
Data Element Description:	Qualifies what identification is used in the Billing Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Must be provided when Billing Provider ID is used.						
Billing Provider ID	80 Max	ANPlus	S	None	Billing Provider Identifier (AN, L=80)	D20	P
Data Element Description:	The Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required when **MA Billing Provider ID** field is not used otherwise it is optional.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Billing Provider Last Name or Organization	35 Max	ANPlus	Y	None	Billing_Provider_Last_ Name_or_Organization (AN, L=35)	D21	P
Data Element Description:	Last name of the billing provider or the name of the individual group/clinic, or organization.						
Validation Rules:							
Billing Provider First Name	25 Max	ANPlus	N	None	Billing_Provider_First_Name (AN, L=25)	D22	P
Data Element Description:	First name of the billing provider.						
Validation Rules:	(Highly encouraged to populate if the Billing Provider is an individual)						
Billing Provider Middle Name	25 Max	ANPlus	N	None	Billing_Provider_Middle_ Name (AN, L=25)	D23	P
Data Element Description:	Full middle name of the billing provider.						
Validation Rules:							
MA Rendering Provider ID	8 Fixed	**N** (00000000)	S	None	NA	D24	P
Data Element Description:	Medicaid Rendering Provider ID						
Validation Rules:	Must exist in the Master Lookup table. When you have a member share transaction, this field must be present, and must equal the CMO MA ID						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Rendering Provider ID-Qualifier	2 Max	AN	S	None	ID Code Qualifier (AN, L=2)	D25	P
Data Element Description:	Qualifies what identification is used in the Rendering Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required if Rendering Provider ID is used.						
Rendering Provider ID	80 Max	ANPlus	S	None	Rendering Provider Identifier (AN, L=80)	D26	P
Data Element Description:	The Rendering Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required if Rendering Provider Last Name is used.						
Rendering Provider Last Name	35 Max	ANPlus	S	None	Rendering_Provider_Last_Name (AN, L=35)	D27	P
Data Element Description:	Last name of the rendering provider.						
Validation Rules:	Required if Rendering Provider ID is used.						
Rendering Provider First Name	25 Max	ANPlus	N	None	Rendering_Provider_ First_Name (AN, L=25)	D28	P
Data Element Description:	First name of the rendering provider.						
Validation Rules:							

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Rendering Provider Middle Name	25 Max	ANPlus	N	None	Rendering_Provider_ Middle_Name (AN, L=25)	D29	P
Data Element Description:	Full middle name of the rendering provider.						
Validation Rules:							
National Health Plan ID	80 Max	AN	N	None		D64	M
Data Element Description:	The national health plan identifier for this plan						
Validation Rules:							
National Recipient ID	80 Max	AN	N	None		D65	M
Data Element Description:	The member's national subscriber identifier.						
Validation Rules:							
Recipient ID	10 Fixed	**N** (0000000000)	Y	None	Patient's Primary Identification Number (AN, L=80)	D30	M
Data Element Description:	Recipient's ten digit Medicaid identification number with no dashs. **Fixed length of 10 numbers.**						
Validation Rules:	Must exist in the Master Lookup table.						
Recipient Last Name	35 Max	ANPlus	Y	None	Patient Last Name (AN, L=35)	D31	M
Data Element Description:	Last name of recipient.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Validation Rules:							
Recipient First Name	25 Max	ANPlus	Y	None	Patient First Name (AN, L=25)	D32	M
Data Element Description:	First name of recipient.						
Validation Rules:							
Recipient Middle Name	25 Max	ANPlus	N	None	Patient Middle Name (AN, L=25)	D33	M
Data Element Description:	Full middle name of recipient.						
Validation Rules:							
Recipient Birth Date	10 Fixed	D (CCYY-MM-DD)	N	None	Birth Date (AN, L=25)	D71	M
Data Element Description:	Birth date for the Recipient/Subscriber						
Validation Rules:							
Recipient Death Date	10 Fixed	D (CCYY-MM-DD)	N	None	Death Date (AN, L=25)	D72	M
Data Element Description:	Death date for the Recipient/Subscriber						
Validation Rules:							
Primary Diagnosis Code	30 Max	ANDot	N	None	Primary Diagnosis (AN, L=30)	D75	S

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Data Element Description:	The full ICD-9 code describing the primary diagnosis (I.e. the condition established after study to be chiefly responsible for causing the admission or health care episode). The diagnosis code found on the Encounter.						
Validation Rules:	Must exist in the Master Lookup table. Principal Diagnosis Code will be supported for a limited time. Must only provide either the Principle or the Primary, not both. If both fields are provided the batch will be rejected. Must be NULL for member share. Diagnosis codes must be filled out sequentially without gaps.						
Second Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D35 S	
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						
Third Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D36 S	
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Fourth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D37	S
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						
Fifth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D38	S
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						
Sixth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D39	S
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						
Seventh Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D40	S
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Eighth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D41	S
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.						
Validation Rules:	Must exist in the Master Lookup table.						
From Date of Service	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date (AN, L=35) From Date and To Date of service are combined into one field on the HIPAA 837 layout	D42	S
Data Element Description:	First date of service.						
Validation Rules:							
To Date of Service	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date (AN, L=35) From Date and To Date of service are combined into one field on the HIPAA 837 layout	D43	S
Data Element Description:	Last date of service.						
Validation Rules:							
National Place of Service	2 Max	AN	S	None	Place of Service Code (AN, L=2)	D44	S
Data Element Description:	National Place of Service Code. (Refer to the place of service appendix in Part K of the WMAP handbook).						
Validation Rules:	Must exist in the Master Lookup table. Required if the SPC specified is a medical SPC. Must be NULL for member share.						
Procedure Code	48 Max	AN	S	None	Procedure Code (AN, L=48)	D46	S
Data Element Description:	CPT, HCPCS, local, or national code. Local codes are approved State Local codes and not County or MCO generated local codes. HCPCS is a 5AN, NDC is 11AN and CPT is 5N						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Validation Rules:	Must exist in the Master Lookup table. Procedure Code or Revenue code is required if the SPC specified is a medical SPC. Required if Revenue Code is not present.						
First Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 1 (AN, L=2)	D47	S
Data Element Description:	Two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Master Lookup table. Modifiers must be filled sequentially without gaps.						
Second Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 2 (AN, L=2)	D48	S
Data Element Description:	Additional two digit modifier code.						
Validation Rules:	Must exist in the Master Lookup table.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Third Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 3 (AN, L=2)	D49	S
Data Element Description:	Additional two digit modifier code.						
Validation Rules:	Must exist in the Master Lookup table.						
Fourth Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 4 (AN, L=2)	D50	S
Data Element Description:	Additional two digit modifier code.						
Validation Rules:	Must exist in the Master Lookup table.						
Revenue Code	4 Max	AN	S	None	NA	D51	S
Data Element Description:	A code which identifies a specific accommodation, ancillary service or billing calculation.						
Validation Rules:	Must exist in the Master Lookup table. Procedure Code or Revenue code is required if the SPC specified is a medical SPC. Required if Procedure Code is not present.						
DRG	3 Max	N	N	None	DRG (N, L< =3)	D73	S
Data Element Description:	The national DRG code if applicable.						
Validation Rules:	Must exist in the Master Lookup table. Must be Null for Member Share.						
Quantity	15(12,3) Max	N (-999999999999.999)	S	None	Service Unit Count (AN, L=15)	D52	S
Data Element Description:	The quantitative measure of service rendered according to the service. **Example the quantity of 35 1/2 can be sent as 35.5, 35.50 or 35.500.**						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for member share transactions.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Unit or Basis for Measurement Code	2 Max	AN	S	None	Unit or Basis for Measurement Code (AN, L=2)	D53	S
Data Element Description:	Describes what format the Quantity field is in. MJ (minutes), HR (hours), Days (DA), Weeks (WK), Years (YR), Quarter (Q1), International Units (F2), UN (unit), and Miles (DH).						
Validation Rules:	Must be present for Encounter transactions. Must be NULL for member share transactions.						
SPC	6 Max	AN (999.99)	Y	None	NA	D74	S
Data Element Description:	The specific program (SPC and Subprogram code) which is provided to the client. The subprogram relates to narrow program initiative if appropriate. Refer to applicable manuals for SPC definitions. Decimal is considered character in a non-numeric field						
Validation Rules:	Must exist in the Master Lookup table. SPC Code + SPC Subprogram Code will be supported for a limited time in 2.0 Must only provide either the SPC Code + SPC Subprogram Code or the SPC, not both. If both "fields" are provided the batch will be rejected.						
Charges	15 (13,2) Max	N (-9999999999999.99)	S	None	Line Item Charge Amount (AN, L-18)	D56	S
Data Element Description:	The amount charged by the Provider. (This is the amount billed for this line item only. If multiple details are being billed on one claim do not enter the total claim billed amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA						
Validation Rules:	Must be provided for an Encounter transaction. Must be NULL for member share transactions.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Receipt Date	10 Fixed	D (CCYY-MM-DD)	Y	None	NA	D57	S
Data Element Description:	The date the claim was received by the MCO from the provider.						
Validation Rules:							
Paid Amount	15 (13,2) Max	N (-9999999999999.99)	Y	None	Payer Paid Amount (AN, L=18)	D58	S
Data Element Description:	The amount paid by the MCO to the provider. (This is the amount paid for this line item only. If multiple details are being paid on one claim do not enter the total claim paid amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA						
Validation Rules:	Must be less than or equal to Charges.						
Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	Adjudication or Payment Date (AN, L=35)	D59	R
Data Element Description:	The date the claim was finalized. For paid claims it is the check date. For denied claims, it is the EOB or notification date. For adjustments it is the posting date.						
Validation Rules:							
TPL Paid Amount	15 (13,2) Max	N (-9999999999999.99)	Y	None	NA	D60	S
Data Element Description:	Detail claim amount paid by third party insurer. (This is the TPL amount paid for this line item only. If multiple TPL details are being paid on one claim do not enter the total TPL paid amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA						
Validation Rules:	Must be present for Encounter Transactions. Must equal "0" for Member share transactions.						

Family Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#	Error cat
Allowed Amount	15 (13,2) Max	N (-9999999999999.99)	S	None	NA	D61	S
Data Element Description:	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. The lesser of the Medicaid Rate, MCO Contracted Rate or the amount Billed/Charged by the Provider. Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA						
Validation Rules:	Must be present for Encounter Transaction. Must be NULL for member share transactions						
Support Indicator	1 Fixed	A (0)	Y	C	NA	D62	S
Data Element Description:	The type of support this service line item represents. S = Self-directed; C = MCO-directed; N = Non-Services						
Validation Rules:	Must be either "C", "N" or "S". Must be "N" for Member share.						
Member Share	1 Fixed	A (0)	Y	N	NA	D63	A
Data Element Description:	The type of member's share. Supported services are: C = Cost Share, R = Room & Board, V = Voluntary Contribution, S= Spenddown or N = None.						
Validation Rules:	Must be either "C", "R", "V", "S" or "N".						

Information regarding Data Type

AN	Alpha numeric
ANPlus	Alpha numeric + special characters
ANDot	Alpha numeric + period
A	Alpha
N	Numeric
D	Data

Information regarding length

(000)	fixed length
(999)	variable length

Information regarding required field

Y	Yes, Data is required in this field for Original or Change New transactions
N	No, Data is not required in this field
S	Situational, Data is required in this field only when certain other criteria is met

Please note, the DD does not specify the severity of the edit. In most cases, it makes sense to set the severity to batch accept or batch reject. But, for business reasons, it may have been set to a Warning

Validation rule

This information is limited to business decisions. We do not go into parser validations, or data integrity validatior